# Complete Summary

## GUIDELINE TITLE

Screening for depression: recommendations and rationale.

## BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med 2002 May 21;136(10):760-4. [13 references]

## COMPLETE SUMMARY CONTENT



## SCOPE

### DISEASE/CONDITION(S)

Depression

### GUIDELINE CATEGORY

Screening

### CLINICAL SPECIALTY

Dermatology
Family Practice
Internal Medicine
Pediatrics
Psychiatry
Psychology

### INTENDED USERS

Advanced Practice Nurses
Nurses

Physician Assistants
Physicians

### GUIDELINE OBJECTIVE(S)

To summarize the third U.S. Preventive Services Task Force (USPSTF) recommendations for screening for depression and the supporting scientific evidence

### TARGET POPULATION

Adults, adolescents, and children seen in primary care

### INTERVENTIONS AND PRACTICES CONSIDERED

#### Screening

1. Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire, Center for Epidemiologic Study Depression Scale, and other screening instruments and asking questions about mood and anhedonia.
2. Full diagnostic interviews using standard diagnostic criteria
3. Recurrent screening

#### Treatment

1. Antidepressants, such as tricyclic antidepressants, selective serotonin reuptake inhibitors, heterocyclic agents, monoamine oxidase inhibitors, and others
2. Psychotherapeutic approaches (cognitive-behavioral therapy or brief psychosocial counseling)
3. Combined medication and psychotherapy
4. Education/quality improvement interventions

### MAJOR OUTCOMES CONSIDERED

- Accuracy (i.e., sensitivity, specificity, and positive or negative predictive value) of screening tests for depression
- Effects of screening and feedback on rates of diagnosis, treatment, and patient outcomes
- Clinical outcomes after treatment of depression, including severity of depression, functional status, and health care utilization

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

## DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

### Literature Search Strategy

To identify articles relevant to the questions of screening and treatment of depression, the Evidence-based Practice Center staff searched the MEDLINE database from 1994 to 1999 and used recent systematic reviews. The authors supplemented these sources by searching the Cochrane database on depression, neurosis, and anxiety disorders; conducting additional specific MEDLINE searches from 1966 to 1994; and hand-searching bibliographies of systematic reviews, relevant original articles, the second edition of the Guide to Clinical Preventive Services, and the 1993 clinical practice guideline on depression from the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality) (Depression in primary care: volume 1. Detection and diagnosis. Rockville [MD]: U.S. Department of Health and Human Services, Agency for Healthcare Policy and Research, 1993. [Clinical practice guideline; no. 5).

The authors established eligibility criteria for all searches. Table 3 in the Systemic Evidence Review (Pignone M, Gaynes BN, Rushton JL, Mulrow CD, Orleans CT, Whitener BL, et al. Screening for depression. Rockville [MD]; Agency for Healthcare Research and Quality; 2002 May. [Systematic evidence review; no. 6]) companion document presents these criteria. The searches were restricted to articles published in English and excluded nonpublished studies, those published in abstract form only, letters, and editorials.

Diagnosis articles were identified by searching for studies with information about diagnostic accuracy, particularly sensitivity and specificity. The authors included only those articles that compared the screening instrument with a criterion standard. For articles on therapy, the search was restricted to randomized controlled trials (RCTs) and meta-analyses of randomized controlled trials. For articles on direct effects of screening and feedback, the authors included randomized controlled trials and before-and-after studies of identification, treatment, or health outcomes.

The authors also used the second edition of the USPSTF Guide to Clinical Preventive Services, as well as systematic reviews, meta-analyses, and evidence-based practice guidelines that addressed screening and treatment of depression, to identify key articles earlier than the 1994 or 1995 period. Finally, the bibliographies of included articles were reviewed to detect any important articles that may have been missed at other steps.

## NUMBER OF SOURCE DOCUMENTS

192 articles were included in the systematic evidence review; 70 articles were included in the evidence tables

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

### Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

### Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

### Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

### Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr;20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

## METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute-University of North Carolina Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Two of the Evidence-based Practice Center staff independently reviewed the titles and abstracts of the articles identified by the literature searches and excluded ones on which they agreed that eligibility criteria were not met. When the initial reviewers disagreed, the articles were carried forward to the next review stage in which the Evidence-based Practice Center team reviewed the full articles and made a final decision about inclusion or exclusion by consensus.

Reviewers entered study design and outcome data from the articles on screening accuracy, screening outcomes, and treatment onto paper abstraction forms. These data were used to construct evidence tables.

To characterize the quality of the included studies, the internal and external validity for each article were rated in the evidence tables using criteria developed by the U.S. Preventive Services Task Force Methods Work Group. Apart from grading individual articles, the aggregate internal validity and external validity as well as the coherence (agreement of the results of the individual studies) for each of the key questions in the analytic framework. Appendix C of the Systemic Evidence Review (Pignone M, Gaynes BN, Rushton JL, Mulrow CD, Orleans CT, Whitener BL, et al. Screening for depression. Rockville [MD]; Agency for Healthcare Research and Quality; 2002 May. [Systematic evidence review; no. 6]) presents the Work Group's detailed criteria for grading individual articles and rating aggregate validity and consistency of the articles reviewed.

In addition to these general criteria, the Evidence-based Practice Center staff developed specific guidelines for the evidence on screening for depression. In diagnostic accuracy studies, the studies were required to have performed verification of screening results against an accepted criterion standard. Studies in which no criterion standard was used were excluded. Studies that reported the results for only the portion of the sample that received the criterion standard were considered to have potential for spectrum bias and were also rated "fair."

For treatment studies, the failure to report results by intention-to-treat led to a grade of "fair" if the difference in sample size at the beginning to the trial was greater than 20% overall or if the drop-out rate was significantly different between the intervention and control groups.

Screening outcomes were excluded if they examined the impact of screening and feedback versus usual care on the diagnosis, treatment, or outcomes of depression.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

## COST ANALYSIS

Several recent cost-effectiveness analyses have addressed the question of whether a modest improvement in depression outcomes warrants the increased effort of screening and providing systematic support for treatment. Valenstein and coworkers developed a cost--utility model to examine the consequences of screening a hypothetical cohort of 40-year-old adults, using estimates derived from the literature. In the base case of their Markov model, they assumed a prevalence of major depression of 8%; a sensitivity and specificity for the detection of major depression of 84% and 85%, respectively; and a cost of screening of $5.00 per person. They also assumed that 35% of patients would have full remission without treatment and that rates of full remission in standard or enhanced care settings would be 45% and 50%, respectively. They estimated that one-time screening had a cost--utility ratio of about $45,000 per quality-adjusted life-year gained; annual screening had a cost of more than $100,000 per quality-adjusted life-year gained.Using data on costs and effectiveness obtained directly from trial by Wells and colleagues, Schoenbaum and coworkers examined

the cost--utility of the screening and treatment support program studied by Wells and colleagues. Relative to usual care, the enhanced program, which included one-time screening and support to improve treatment, yielded additional benefits at a cost of $10,000 to $35,000 per quality-adjusted life-year gained. In a similar analysis that used data obtained directly from the study by Katzelnick and associates, Simon and colleagues found a cost per depression-free day gained of $51.84 (CI, $17.37 to $108.47).

Cost-effectiveness data from the two recent trials of systematic efforts to screen for depression and provide integrated support for treatment suggest that such programs can be implemented efficiently and can produce cost-effectiveness ratios similar to those of other commonly performed preventive services, such as screening for mammography in women older than 50 years of age or treatment of mild to moderate hypertension. Further research is required to determine which components of these integrated programs are most effective and to determine whether more efficient means of delivering effective care are possible.

## METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review: Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

For this guideline, outside reviewers were representatives of key primary care professional associations that have formal liaison ties to the U.S. PREVENTIVE SERVICES TASK FORCE , a representative of the Canadian Task Force on Preventive Health Care, representatives of other professional societies, clinical experts in the area of depression, staff of the Agency for Healthcare Research and Quality, and representatives of other relevant federal agencies.

Recommendations of Others: Recommendations related to screening for depression from the following groups were discussed: the Canadian Task Force on

Preventive Health Care, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Medical Association.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Grade B recommendation.

The U.S. Preventive Services Task Force found good evidence that screening improves the accurate identification of depressed patients in primary care settings and that treatment of depressed adults identified in primary care settings decreases clinical morbidity. Trials that have directly evaluated the effect of screening on clinical outcomes have shown mixed results. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. U.S. Preventive Services Task Force concluded that the benefits of screening are likely to outweigh any potential harms.

- The U.S. Preventive Services Task Force concludes the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression. Grade I recommendation.

The U.S. Preventive Services Task Force found limited evidence on the accuracy and reliability of screening tests in children and adolescents and limited evidence on the effectiveness of therapy in children and adolescents identified in primary care settings.

#### Clinical Considerations

- Many formal screening tools are available (e.g., the Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire, and Center for Epidemiologic Study Depression Scale [CES-D]). Asking two simple questions about mood and anhedonia ("Over the past 2 weeks, have you felt down, depressed, or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?") may be as effective as using longer instruments. There is little evidence to recommend one screening method over another, so clinicians can choose the method that best fits their personal preference, the patient population served, and the practice setting.
- All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (for example, those from the fourth edition of

Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression or dysthymia. The severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, or substance abuse) should be addressed.

- Many risk factors for depression (e.g., female sex, family history of depression, unemployment, and chronic disease) are common, but the presence of risk factors alone cannot distinguish depressed from nondepressed patients.
- The optimal interval for screening is unknown. Recurrent screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (e.g., panic disorder or generalized anxiety), substance abuse, or chronic pain.
- Clinical practices that screen for depression should have systems in place to ensure that positive screening results are followed by accurate diagnosis, effective treatment, and careful follow-up. Benefits from screening are unlikely to be realized unless such systems are functioning well.
- Treatment may include antidepressants or specific psychotherapeutic approaches (e.g., cognitive-behavioral therapy or brief psychosocial counseling), alone or in combination.
- The benefits of routinely screening children and adolescents for depression are not known. The existing literature suggests that screening tests perform reasonably well in adolescents and that treatments are effective, but the clinical impact of routine depression screening has not been studied in pediatric populations in primary care settings. Clinicians should remain alert for possible signs of depression in younger patients. The predictive value of positive screening tests is lower in children and adolescents than in adults, and research on the effectiveness of primary care-based interventions for depression in this age group is limited.

Definitions:

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The US Preventive Services Task Force found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

#### Effectiveness of Screening

The review for the U.S. Preventive Services Task Force identified 14 randomized, controlled trials that have examined the effectiveness of screening for depression in primary care settings. In 8 studies, the only intervention was feedback of screening results to clinicians; remaining studies combined feedback with other interventions for patients or clinicians.

The trials reported various outcomes, including recognition of depression, rates of treatment, and clinical improvement among patients with depression. In 7 trials, routine depression screening with feedback of screening results to providers generally increased recognition of depression, especially major depression, by a factor of two to three compared with usual care. Trials that examined the effect of feedback of screening results on the proportion of depressed patients who received treatment showed mixed results: in 4 fair- to good-quality trials that used feedback alone, there was no significant effect on treatment rates, but 4 of the 5 trials that combined feedback with treatment advice or other system supports reported increased treatment rates in the intervention group compared with "usual care." Ten trials measured the effect of screening and feedback on depression outcomes from 1 month to 2 years after the intervention. Five of these 10 studies reported significant improvements in the clinical outcomes of depressed patients, and 3 others reported improvements that did not reach statistical significance. All three trials that compared the effects of integrated recognition and management programs with "usual care" in community primary care practices showed significantly improved patient outcomes. Integrated programs included feedback, provider or patient education, access to case management or mental health care, telephone follow-up, and institutional commitment to quality improvement. One trial, which included both newly detected cases of depression and patients already under treatment, showed improvement in patient symptoms at 6 months only among patients beginning a new treatment episode. No improvement was noted among patients who had been recently treated (i.e., those who would have been identified without specific screening). Two trials showed improved symptoms at 12 months; one of these also showed more employment retention in intervention compared with usual care patients. All three trials required allocation of clinic resources to detection and management programs.

On the basis of estimates from the above-mentioned trials, approximately 11 patients identified as depressed as a result of screening would need to be treated to produce 1 additional remission. If depression (including major depression, dysthymia, and minor depression) is present in 10% of primary care patients, then 110 patients would need to be screened to produce 1 additional remission after 6 to 12 months of treatment. The number needed to treat for benefit would

be smaller for patients with major depression only, but a larger group would need to be screened to identify them.

## POTENTIAL HARMS

### Potential Harms of Screening and Treatment

The potential harms of screening include false-positive screening results, the inconvenience of further diagnostic work-up, the adverse effects and costs of treatment for patients who are incorrectly identified as being depressed, and potential adverse effects of labeling. None of the research reviewed provided useful empirical data regarding these potential adverse effects.

# IMPLEMENTATION OF THE GUIDELINE

## DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the Guide ("Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach") - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as

patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

## IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

## RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

- Screening for Depression. What's New from the USPSTF.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med 2002 May 21;136(10):760-4. [13 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

1996 (revised 2002 May)

### GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

### GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

### SOURCE(S) OF FUNDING

United States Government

### GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

### COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Alfred O. Berg, MD, MPH, (Chair); Janet D. Allan, PhD, RN, CS, (Vice-chair); Paul S. Frame, MD; Charles J. Homer, MD, MPH; *Mark S.

Johnson, MD, MPH; *Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; C. Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J. Pender, PhD, RN; *Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH.

*These current members were not on the Task Force at the time that this particular recommendation was voted.

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

## GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for depression. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from the Annals of Internal Medicine Online and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Pignone M, Gaynes BN, Rushton JL, Mulrow CD, Orleans CT, Whitener BL, et al. Screening for depression. Rockville (MD); Agency for Healthcare Research and Quality; 2002 May. (Systematic evidence review; no. 6). AHRQ publication no. AHRQ02-S002.

- Pignone MP, Gaynes BN, Rushton JL, Burchell CM, Orleans CT, Mulrow CD, et al. Screening for depression in adults: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2002;136(10):765-76.

  Electronic copies: Available from the USPSTF Web site and the Annals of Internal Medicine Online.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

  Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

- The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.
- Screening for depression. What's new from the USPSTF. Rockville (MD): Agency for Healthcare Research and Quality; 2002 May. Electronic copies: Available from USPSTF Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC STATUS

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